U.S. Public Health Service
Commissioned Corps Readiness Force
Student Application

Please initial next to each line on the form below confirming that you have met the CCRF course prerequisites. Fax this page along with your completed course application and a copy (front and back) of your BLS for Healthcare Providers card to the CCRF fax number on the following page.

INITIAL	APPLICATION PREREQUISITES
	Supervisor's permission to attend.
	Own at least 2 complete pairs of the working khakis.
	Completed physical exam (including medical review) on file with DCP within past 5 years.
	Certified in AHA BLS for Healthcare Providers and recorded on CCRF Officer Summary Page. **You must fax a copy of your BLS card (front and back) with your application.**
	Current licensure (if applicable) on file with DCP and recorded on CCRF Officer Summary Page.
	Immunization requirements completed (Hep A + B series started) **and recorded** on CCRF Officer Summary Page.
	Current APFT recorded on CCRF Officer Summary Page.
	Recorded height and weight on CCRF Officer Summary Page.
	Recorded the number of hours you practice your professional skill on CCRF Officer Summary Page.
	Current login and update of CCRF Officer Summary Page.
	Completion of most or all sessions on the CCRF Online Training Program.

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12300 Twinbrook Parkway · Suite 360 · Rockville, MD 20857
Fax (301) 443-3119

APPLICATIONS MUST BE TYPEWRITTEN **(YOU MUST FILL IN EACH FIELD)**

Course Title:	Course Date: **Select only ONE course date**
Combined Humanitarian Assistance Response Training Course (CHART)	☐ **February 2-6, 2004**
Joint Operations Medical Managers Course (JOMMC)	☐ **January 11-16, 2004**
Radiation: "Truth or Consequences": A Course for Clinicians and Scientists	☐ **January 27-29, 2004**

PHS Serial Number (SERNO)	S.S.N.	# Clinical Hours Within the past 12 months	BLS for Healthcare Provider Expiration Date

Name (LAST) (FIRST)	Rank:	PHS Category:

Home Address:	City, State, Zip Code:

Home E-Mail:	Home Phone:	Mobile/Pager:

Duty Station Address:	City, State, Zip Code:

Work E-Mail:	Work Phone:	Work Fax:

OPDIV/Agency:	Current Job Title:

Mode of Transportation: check applicable		If traveling by air, please specify Airports of **Departure**:	
☐ Automobile	☐ Air Travel	1st Choice	2nd Choice

Have you attended this course in the past?
☐ No ☐ Yes If yes, when?

Why do you think you should be selected for this course?

Supervisor's Name	Supervisor's Signature Date